Diane Powell, PhD, LPC and Associates

Paul Loosemore, MAC

Individual, Marriage & Family Therapy
1715 Deer Tracks Trail, Suite 260
St Louis, MO 63131
(314) 570-7463

Fee_____ Diag. Code_____ Diag. Rec._____ Ins. Pay_____ Copay_____ 1LUC/ADL_____

To make our first meeting more productive, please give accurate and complete responses to every section of this form. If necessary, write additional information in the margins.

PERSONAL AND FAMILY INFORMATION

Date: _____

Full Name: _____ Date of Birth: _____ Age: _____

Address: _____ City _____ State_____ Zip_____

May I send mail (e.g., a bill or other necessary information) to this address? Please initial: _____yes_____no

Phone (home) _____(Cell)_____(Work)_____

Soc. Sec. # _____ - _____ -_____

Education: Circle last year of school completed: 9 10 11 12 GED College: 1 2 3 4 Other _____

Employed by _____ Position _____How long _____

Church Home: _____

Marital Status: Single, never married ___ Engaged ___; Living together without marriage ___; Separated ___ how long ___;

Divorced ___ how long ___ ; Widow(er) ___ how long ___; Married ___ Spouse's Name: _____Age ___

Phone # _____ Spouse's occupation: _____ Employer_____ How

long married to this spouse _____ ; Total number of prior marriages for you ___ For your spouse ___

Children	Age	Sex	Grade in School	Relationship to you	Live in your home?
_____	____	____	_____	_____	_____
_____	____	____	_____	_____	_____
_____	____	____	_____	_____	_____
_____	____	____	_____	_____	_____

COUNSELING HISTORY

Have you previously sought counseling? Yes ____ No ____

Therapist_____ Profession _____ From _____ To _____

Therapist_____ Profession _____ From _____ To _____

How satisfactory was your experience(s)?_____

_____

Are you presently working with any other Counselor or Psychologist? Yes ____ No ____

For what reason? _____ Counselor name _____

Are you involved in any other counseling or support group? Yes ____ No ____ Specify _____

MEDICAL INFORMATION

Family Physician _____ Psychiatrist _____

Are you taking any prescription drugs? Yes ____ No ____ If Yes, state the drug name (s), type and for what purpose?

_____

_____

Who prescribed the drug(s)? _____ How often do you see this doctor? _____

Describe your physical health? Very good ___ Good ___ Adequate ___ Poor ___ Declining ___

Current medical problems and/or medications. _____

_____

Please list any sleep disturbances. _____

Have you ever been hospitalized for mental illness or substance abuse? Yes ____ No ____ If yes, for what reason? ____

_____ How long in treatment? _____

Hospital name _____ How long ago? _____Did you continue with

Outpatient counseling? Yes ____ No ____ Name of Counselor _____

CONSENT FOR TREATMENT

Client Name_____

Date of Birth_____

Counselor _____

I give permission to Paul Loosemore, MAC, to provide counseling to me.

As a client of my office it is your right to have the content of your therapy sessions held in confidence with these exceptions in which I am mandated by law to report:

1) if you sign a release form for me to divulge any or all information,
2) if you intend suicide, or if you intend to do serious physical harm to yourself,
3) if you intend homicide,
4) if a child, elderly person, or disabled person is being abused or has been abused, or
5) in the case of exploitation by a mental health professional.

In some cases, the Missouri courts have held that if an individual intends to take harmful or dangerous action against another individual, it is the counselor's duty to warn the person and/or the family of the person who is likely to suffer the results of harmful behavior.

Every effort will be made to resolve these issues before such a violation of confidentially takes place. Every effort will be made to prevent an attempted suicide or a dangerous action against another person.

Professional consultation:
In following ethical and professional standards, occasionally therapists consult with other professionals to gain other perspectives and ideas on how to best serve you. Unless you have signed a release, no identifying information is shared during these consultations.

By signing below, I affirm that the information given on this form is true and complete.

I have read and agree to the above policies, procedures and statements.

_____	_____	_____
Signature of Client	Printed Name of Client	Date

_____	_____
Signature of Counselor	Date

Diane Powell, PhD, LPC
Paul Loosemore, MAC
1715 Deer Tracks Trail, Suite 260
St. Louis, MO 63131
(314) 570-7463
Fax (314) 394-1404

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

MY LEGAL DUTY

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, my legal duties, and your rights concerning your health information. I must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (05/18/10), and will remain in effect until I replace it.

I reserve the right to change my privacy practices and as applicable law permits the terms of this Notice at any time, reflecting such changes. I reserve the right to make the changes in my privacy practices and the new terms of my Notice effective for all health information that I maintain, including health information I created or received before I made the changes. Before I make significant change in my privacy practices, I will change this Notice and make the new Notice available upon request.

You may request a copy of my Notice at any time. For more information about my privacy practice, or for additional copies of this Notice, please contact me using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

I use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: I may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: I may use and disclose your health information to obtain payment for services I provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to my use of your health information for treatment, payment or healthcare operations, you may give me written authorization to use your health information or to disclose it to anyone for any purpose. If you give me an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give me a

written authorization, I cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: I must disclose your health information to you, as described in the Patient Rights section of this Notice. I may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but *only* if you agree that I may do so.

Persons Involved In Care: I may use or disclose your health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, I will provide you with an opportunity to object to such uses or disclosures. In event of your incapacity or emergency circumstances, I will disclose health information based on determination using my professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. I will also use my professional judgment and my experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: I will not use your health information for marketing communications without your written authorization.

Required by Law: I may use or disclose your health information when I am required to do so by law.

Abuse or Neglect: I may disclose your health information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. I may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: I may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. I may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. I may disclose to a correctional institution or a law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: I may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, within limited exceptions. You may request that I provide copies in a format other than photocopies. I will use the format you request unless I cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. I will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending me a letter to the address at the end of this Notice. If you request copies, I will charge you $25.00 for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, I will charge a cost-based fee for providing your health information in that format. If you prefer, I will prepare a summary or an explanation of your health information for a fee. Contact me using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which I disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for 6 years following the first day of your treatment, but not before May 18, 2010. If you request this accounting more than once in a 12-month period, I may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that I place additional restrictions on our use or disclosure of your health information. I am not required to agree to these additional restrictions, but if I do, I will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that I communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that I amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) I may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on my Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about my privacy practices or have questions or concerns, please contact me.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with my office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this Notice or the policies and procedures of our office. I will not retaliate against you for filing a complaint. I will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. You may complain to me using the contact information listed at the end of this Notice.

I support your right to the privacy of your health information.

Contact: Dr. Diane Powell
Telephone: 314-570-7463
Address: 1715 Deer Tracks Trail, Suite 260 St. Louis, MO 63131

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices from Liz Colizza, MAC under supervision of Diane Powell, PhD, LPC.

{Please Print Name} _____

{Signature} _____

{Date} _____

For Office Use Only

I attempted to obtain written acknowledgement of receipt of my Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)